STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS As a result of the investigation of incident #62882-I, deficiencies were written at W153 and W288.	W 000	See attached	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and records review, the facility failed to ensure staff immediately reported allegations of abuse/mistreatment to the administrator. Consequently, the facility failed to report all allegations of abuse/mistreatment timely to the Department of Inspections and Appeals per state law and facility policy. This affected 1 of 1 client (Client #1) identified during the investigation of incident #62882-I (Client #1). Findings follow: Record review on 10/10/16 revealed a facility Suspected Abuse Form signed by the Nurse Coordinator on 8/26/16. The document recorded the Nurse Coordinator's observations of the Client Support Staff/Shift Leader's (CSS/SL) interactions with Client #1 on 8/23/16. The report noted Client #1 screamed and yelled and the CSS/SL yelled back at him/her. In addition, the CSS/SL reportedly threatened to take Client #1's personal belongings. The document noted the date of the incident as 8/23/16 and the date reported as 8/25/16. Further review revealed a copy of an e-mail the Nurse Coordinator sent to	W 153	POC 10/21/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 1 the Residential Supervisor (RS) describing the incident on 8/23/16. The e-mail was sent on 8/25/16 at 10:03 a.m. Additional record review revealed Witness Statement Forms signed by Client Support Staff (CSS) A and CSS B on 8/29/16. CSS A wrote her account of an interaction between the CSS/SL and Client #1 on 8/23/16. She noted the CSS/SL invaded Client #1's personal space and told him/her to listen or she would take his/her cell phone. CSS B documented the CSS/SL told Client #1 if he/she didn't stop yelling, the CSS/SL would take his/her cell phone. Record review of the facility Prevention and Reporting of Dependent Adult and Child Abuse policy on 10/10/16 revealed the policy stated, "Any employee who witnesses an incident that might be considered abuse shall verbally report the incident to the supervisor of the area in which the incident occurred. Immediately means without delay following recognition of the incident." When interviewed on 10/11/16 at 8:55 a.m., the Nurse Coordinator said she heard Client #1 yelling and crying from her office around 2:00 p.m. on 8/23/16. She recalled she went to the dining room and the CSS/SL yelled at Client #1 and threatened to take a personal possession. She stated CSS A and CSS B sat in the dining room with Client #1 and witnessed the interaction. The Nurse Coordinator instructed CSS B to talk with the supervisor and CSS A to write down what she saw/heard. She confirmed she thought about the interaction later and determined it might be abuse so she sent an e-mail to the RS on 8/25/16. She stated she also sent the e-mail to	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 2	W 153		

the Campus Residential Director. The Nurse Coordinator failed to report the incident to anyone until 8/25/16.

When interviewed on 10/11/16 at 11:50 a.m., CSS A confirmed she heard the CSS/SL tell Client #1 she would take away his/her cell phone on 8/23/16. She stated she feared the CSS/SL might yell at her so she failed to report the incident to anyone at the time. When re-interviewed on 10/12/16 at 10:40 a.m., she confirmed the Nurse Coordinator instructed her to write down what she saw/heard on 8/23/16. She stated she failed to write anything down until the facility conducted an internal investigation.

When interviewed on 10/11/16 at 1:00 p.m., CSS B confirmed she witnessed an incident between the CSS/SL and Client #1 on 8/23/16. She recalled the CSS/SL leaned down into Client #1's face and told him/her she would keep his/her cell phone all night if the behavior continued. She confirmed she failed to tell anyone until the next day (8/24/16) when she talked to the RS.

When interviewed on 10/10/16 at 3:30 p.m., the RA confirmed she spoke with CSS B on 8/24/16 at approximately 3:30 p.m. She said CSS B told her the CSS/SL had been disrespectful to Client #1 on 8/23/16 and threatened to take away his/her cell phone. She questioned whether the phone was taken and learned it wasn't. She assured CSS B she would follow up with the CSS/SL. She said she intended to follow up with the CSS/SL on 8/27/16 when she returned to work. The RA confirmed she received an e-mail from the Nurse Coordinator on 8/25/16, but failed to read the entire e-mail because she had talked with CSS B and assumed she already knew all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 3 the information. She recalled the Campus Residential Director called her on 8/26/16 and questioned her about the incident. The RA said she read the entire e-mail from the Nursing Coordinator and realized she failed to report an allegation of abuse. When interviewed on 10/12/16 at 9:34 a.m., the Campus Residential Director stated she read an e-mail from the Nurse Coordinator in the afternoon on 8/25/16. She confirmed she spoke with the RA about the incident on 8/26/16 and initiated an internal investigation due to an allegation of abuse. When interviewed on 10/12/16 at 9:15 a.m., the Incident Management Specialist confirmed she conducted an internal investigation of alleged abuse between the CSS/SL and Client #1. She confirmed the incident occurred on 8/23/16 but staff failed to immediately report the incident per facility policy. She further confirmed she reported the incident to the Department of Inspections and Appeals on 8/26/16.	W 153		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff consistently implemented interventions as outlined in client Behavior Support Plans (BSP). This affected 1 of 1 client identified during the investigation of	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288	Continued From page 4 incident #62882-I (Client #1). Findings follow: Record review on 10/10/16 revealed Client #1's BSP to learn to work through upsetting situations. The plan identified Client #1's history of aggression toward self or others when upset. Defined behaviors included: hitting, spitting, scratching, pinching, kicking, biting and throwing things at people or screaming and threatening harm to another. Episodes of screaming or crying in a tone higher than a conversational tone of voice were defined as outbursts. Instructional methods included giving Client #1 a choice to go to another area, diminishing upsetting situations, asking if he/she needed to wear gloves to keep self and others safe, and stating natural consequences (e.g. if you aggress toward a peer, they may aggress toward you). Staff guidance included talking with Client #1 when participating in leisure activities and asking about his/her day, encouraging him/her to talk about feelings. The intervention procedure noted if Client #1 yelled or aggressed, staff should ask him/her to "Stop and Think" and position themselves between Client #1 and any person he/she targeted. Restrictive measures outlined in the BSP included use of psychotropic medication, exclusionary break (removal to his/her bedroom) response cost (use of padded gloves when aggressive towards others) and response cost (remain in central area after an incident of self-harm or suicide ideation). The BSP contained no direction to staff to threaten to take Client #1's phone for any behavior. Continued record review on 10/10/16 revealed a	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288	Continued From page 5 Suspected Abuse Form signed by the Nurse Coordinator on 8/26/16. The form noted on 8/23/16 between 2:00 p.m. and 3:00 p.m., the Nurse Coordinator heard Client #1 crying and yelling in the dining room. She went to the dining room and heard Client #1 say he/she wanted to run away and missed his/her sister. She heard the Client Support Staff/Shift Leader (CSS/SL) tell Client #1 to go ahead and leave and she would help him/her pack. The CSS/SL then threatened to take some personal item from Client #1 if he/she continued yelling/screaming. The Nurse Coordinator noted staff in the area took Client #1 to the window and talked with him/her and he/she calmed down. When interviewed on 10/10/16 at 3:30 p.m., the Residential Supervisor (RS) confirmed Client Support Staff (CSS) B told her the CSS/SL told Client #1 he/she was being "ridiculous" on 8/23/16 and threatened to take his/her cell phone. She stated Client #1's BSP gave staff very specific instruction regarding how to deal with Client #1's behaviors. She confirmed threatening to take personal property was not included in the BSP. When interviewed on 10/11/16 at 8:55 a.m., the Nurse Coordinator confirmed she heard the CSS/LS "match" Client #1's yelling on 8/23/16. She stated the louder Client #1 became, the louder the CSS/LS became. She recalled the CSS/LS threatened to take something from Client #1 but she couldn't recall what item. She stated staff are to change the environment or talk about something positive when Client #1 got upset. She noted the CSS/SL intervention was inappropriate.	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288	Continued From page 6 When interviewed on 10/11/16 at 10:35 a.m., the CSS/Cook stated staff should talk to Client #1 to try to calm him/her. She acknowledged the BSP included use of gloves and a break out of the area. She noted staff would not threaten to take Client #1's cell phone. When interviewed on 10/11/16 at 11:25 a.m., CSS C stated staff should talk to Client #1 if he/she got upset to help him/her deal with feelings. She said, "Never" when asked if Client #1's phone should be taken away if he/she yelled/screamed. When interviewed on 10/11/16 at 11:50 a.m., CSS A confirmed she heard the CSS/SL tell Client #1 she would take his/her cell phone if he/she continued to scream/yell on 8/23/16. She further confirmed loss of his/her cell phone was not a part of Client #1's BSP. When interviewed on 10/11/16 at 1:00 p.m., CSS B stated she heard the CSS/SL tell Client #1 she would take his/her cell phone if his/her behavior continued. She noted the CSS/SL told Client #1 his/her behavior was "ridiculous." She confirmed CSS/SL's intervention intensified Client #1's behavior. She said staff should speak calmly to Client #1 and divert her attention to something positive when he/she screamed. When interviewed on 10/11/16 at 2:15 p.m., CSS D confirmed she started a leisure activity with Client #1 on 8/23/16. She recalled Client #1 got upset and yelled, "I hate you!" and "Go away!" She stated CSS B approached Client #1 and prompted him/her to "Stop and Think." She didn't see any interaction between the CSS/SL and Client #1, but noted staff would not take his/her	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 10/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 288	Continued From page 7 phone for yelling/screaming. When interviewed on 10/11/16 at 2:40 p.m., the Qualified Intellectual Disability Professional (QIDP) confirmed Client #1's BSP included some restrictive measures, but did not include loss of his/her cell phone for yelling/screaming. She noted staff should first redirect him/her to another topic or area when he/she engaged in the behavior(s).	W 288		

VGK 11/7/16 CAC 11/7/16

newHope

New Hope Village
Plan of Correction
Date: 10/24/16

W153 Staff treatment of Clients
W 288-Management of Inappropriate Client Behavior

Target Completion Date: 10/1/16

W 153 Staff Treatment of Clients

Action Plan:

1. Follow up completed with staff that failed to report the allegation of abuse per New Hope policy, in September 2016.
2. Re-training on the reporting procedures in the Prevention and Reporting of Suspected Dependant Adult and Child Abuse policy was sent out in the electronic documentation system to all campus staff on 10/21/16.
3. New Hope has added a new supervisory position to the Evening and Overnight shifts. This Residential Supervisor 2 is present on-campus and will be making rounds of all units throughout each shift and it will be part of their responsibility to complete an end of shift checklist to see if there were any concerns that need to be reported as possible abuse prior to them leaving shift.

Compliance monitoring:

1. The above will be monitored through the following:
    a. Observations in the homes by Supervisors, Residential Supervisor 2's, QIDP's and other leadership staff.
    b. Immediate follow up for staff failing to report timely per policy for any suspected mistreatment or abuse.

Persons Responsible:

All New Hope staff
Residential Supervisors
QIDP's
RS2's
Nurse Coordinators
Campus Residential Director

Date to be completed: 11/1/16

W 288-Management of Inappropriate Client Behavior

Action Plan:

a. Follow up and retraining completed with the alleged perpetrator on 10/17/16, prior to returning to work.
b. Retraining on client #139's Behavior Support plan completed with Prairie Rose staff on 9/14/16.
c. Meeting minutes for Prairie Rose staff, to catch those not present at the staff meeting, was sent out via electronic documentation on 9/21/16 regarding client # 139's behavior support plan.

Compliance Monitoring

1. The above will be monitored through the following:
   a. Observations in the home by Supervisors, shift leaders, Residential Supervisor 2's and QIDP to ensure compliance with behavior programming.

Persons Responsible:

QIDP
Residential Supervisor
Residential Supervisor 2
Campus Residential Director

Lynn McGuire, Campus Residential Director — Date: 10/24/16

Kim Platt, Dir. Of Residential Services — Date: 10-24-16

LeAn Taylor, Assistant Executive Director — Date: 10-24-16